

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL NORTHERN INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W 4TH ST STE 200 MISHAWAKA, IN 46544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00093131</p> <p>Unsubstantiated: lack of sufficient evidence</p> <p>Date: 1/12/12</p> <p>Facility Number: 002605</p> <p>Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor</p> <p>Kindred Hospital Northern Indiana is in compliance with 410 IAC 15-1.5-2, Infection control, 410 IAC 15-1.5-5, Medical staff, and 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 01/25/12</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1